AMIR SALIM, M.D. P.A.
450 N. Texas Avenue Suite C
Webster, TX 77598
281-557-0707 (phone); 281-557-3670 (fax)

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:
Patient's Name:_____DOB:_____SSN:_____(optional)

I authorize the following individual or organization to DISCLOSE the above named individual's health information:
_____ Phone: _____Fax:_____
Address:_____

This information may be DISCLOSED TO and used by the following individual or organization:
_____Phone: _____ Fax:_____
Address:_____

Purpose of Disclosure: __Continuing Patient Care __Changing PCP Other: _____

Please release ALL of the following or Specify by checking items below:

__Problem List	__X-ray/Imaging reports from (date) _____ to (date) _____
__Progress Notes	__Laboratory Results from (date) _____to (date) _____
__History/Physical Exam	__Other Diagnostic Reports (specify)
__Medication List	__EKG reports
__Immunization Record	__Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.
__YES, I consent to release this information __NO, I do not consent to release the information

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFRI64.524. I understand that any disclosure of information carries with it potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (if Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASE DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold the physician or the corporation liable for any misinterpretation in my medical records as result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness